FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

May 17, 2007

Michael G. Andrus
Franklin County Medical Center
44 North 1st East
Preston, ID 83263

Dear Mr. Andrus:

This is to advise you of the findings of the Medicare Swing Bed survey of Franklin County Medical Center which was done on May 10, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form HCFA-2567, listing Medicare Deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for **all** individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the deficient system to insure compliance is achieved and maintained. Included how the monitoring will be done and at what frequency.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 30, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office.

Sincerely,

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131322	A. BUILDING _____ B. WING _____	05/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER	44 NORTH FIRST EAST PRESTON, ID 83263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiency was cited during the Medicare recertification survey of your Critical Access Hospital (CAH). The surveyors conducting the Medicare recertification survey were: Penny Salow, R.N., H.F.S., Team Leader Rae Jean Mc Phillips, R.N., H.F.S.	C 000		
C 304	485.638(a)(4)(i) RECORDS SYSTEM For each patient receiving health care services, the CAH maintains a record that includes, as applicable, identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to maintain records for 2 of 6 patients (#9 and 22), who were reviewed for surgical procedures, that included evidence of properly executed informed consent forms. The findings include: 1. Closed records for 2 of 6 patients, who had surgical procedures performed, lacked properly executed informed consent as follows: * Patient #22, a 17 year old female, was admitted through the emergency room on 12/25/06. The patient had experienced an incomplete spontaneous abortion. A vacuum dilation and curettage was performed under conscious sedation. The record contained a form titled "CONSENT TO MEDICAL OR SURGICAL	C 304	1. We are unable to correct surgical consents on past cases. We will ensure that all surgical consent forms will have properly executed informed consents. We are asking that all physicians ensure that the surgical consent form has: who the procedure is being performed on who is performing the procedure what are the risks specific to the procedure and that all signatures are dated and timed. 2. The Quality Management Coordinator for the hospital, licensed staff and administrative assistant will monitor all surgical consents to ensure they are filled out completely. (See attached Quality Management Indicator sheet and monitoring form). The consents will be audited daily X 14 days, weekly X 4 weeks and monthly X 6 months. The hospital administrator will talk with each of the three (3) active medical staff individually to explain the importance of properly executed informed consents . The Medical Staff as a group, will review the process at the next monthly Medical Staff meeting on June 8th. The monitoring process and results will be reviewed at each monthly medical staff meeting. 3. The deficiency will be corrected on June 8th, 2007.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Admin 5-24-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131322	A. BUILDING _____ B. WING _____	05/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY MEDICAL CENTER	44 NORTH FIRST EAST PRESTON, ID 83263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 304	Continued From page 1 PROCEDURES." The consent form was signed by the patient. However, the consent form did not state who the procedure was being performed on, what the procedure was, who was performing the procedure, or what, if any, risks were specific to the procedure. The patient's signature was not signed as witnessed, dated or timed. * Patient #9, a 31 year old female, was admitted on 3/2/07, for laparoscopic cholecystectomy and intraoperative cholangiogram. The record contained a form titled "CONSENT TO MEDICAL OR SURGICAL PROCEDURES." The consent form did not state who the procedure was being performed on, what the procedure was, who was performing the procedure, or what, if any, risks were specific to the procedure. The consent form was signed by the patient and dated, but the time was not documented. The patient's signature was witnessed and dated, but the time was not documented. 2. The records were reviewed with the Director of Nursing on 5/10/07 at 11:30 AM. She stated the consents were not complete.	C 304		